



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

PINE CREEK MEDICAL CENTER  
9032 HARRY HINES BLVD  
DALLAS TX 75235-1720

#### **Respondent Name**

HARTFORD INSURANCE CO OF THE MIDWEST

#### **Carrier's Austin Representative Box**

Box Number 47

#### **MFDR Tracking Number**

M4-12-0932-01

#### **MFDR Date Received**

November 21, 2011

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "After further review of how this claim was paid it appears that all of the CPT codes fall under status indicator (S) which means these codes do not fall under the multiple procedure rule and should be paid at a 100% of the fee schedule."

**Amount in Dispute:** \$19,317.71

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Based on the policy governing device intensive procedures the carrier has made payment for the service portion of the APC multiplied by 20% with an additional payment of the device cost pursuant to Texas Guidelines."

**Response Submitted by:** The Hartford, 300 South State Street, Syracuse, New York 13202

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 28, 2011	Outpatient Hospital Services	\$19,317.71	\$19,317.71

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- 217 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Workers' Compensation only)
- 217 – BASED ON PAYER REASONABLE AND CUSTOMARY FEES. REIMBURSEMENT MADE BASED ON INS CARRIER FAIR AND REASONABLE REIMBURSEMENT METHODOLOGY. CHARGES DISCOUNTED PER REVIEW BY QMEDTRIX. PLS CALL QMEDTRIX @ 1-800-833-1933 FOR QUESTIONS.
- 97 – Payment is included in the allowance for another service/procedure.
- W1 – Workers Compensation State Fee Schedule Adjustment
- W1 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT. FOR QUESTIONS REGARDING THIS ADJUSTMENT, PLEASE CALL QMEDTRIX AT 1-800-833-1993.
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. IMPLANTABLES & ORTHOTICS AND PROSTHETICS ARE REIMBURSED AT COST TO THE HOSPITAL PLUS 10% PER THE TEXAS ACUTE CARE INPATIENT HOSPITAL FEE GUIDELINE.
- 173 – SERVICE WAS NOT PRESCRIBED BY A PHYSICIAN. DIRECT ADMISSION TO OBSERVATION IS REIMBURSED AFTER BEING SEEN BY A COMMUNITY PHYSICIAN PER RULE 134.403(D).
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### **Issues**

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to reimbursement?

### **Findings**

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. The respondent's position statement asserts that "Policies regarding device intensive procedures has been discussed and referenced in the TDI/DWC § 134.402 rules and comments. Based on the policy governing device intensive procedures the carrier has made payment for the service portion of the APC multiplied by 20% with an additional payment of the device cost pursuant to Texas Guidelines." Review of the Texas Department of State Health Services records finds that the health care provider is licensed as a general hospital and not as an ambulatory surgical center. Therefore, the rules regarding device-intensive procedures as found in the *Ambulatory Surgical Center Fee Guideline* at 28 Texas Administrative Code §134.402, are not applicable to the services in dispute. The applicable rule for the services in this dispute is the *Hospital Facility Fee Guideline – Outpatient*, as found in §134.403, which, the Division notes, does not include special provisions concerning device-intensive procedures.

This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables.

Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are \$88,570.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into

payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

- Procedure code C1778 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code C1787 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code C1820 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code 76001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code 63685 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0039, which, per OPPS Addendum A, has a payment rate of \$14,743.58. This amount multiplied by 60% yields an unadjusted labor-related amount of \$8,846.15. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of \$8,594.92. The non-labor related portion is 40% of the APC rate or \$5,897.43. The sum of the labor and non-labor related amounts is \$14,492.35. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.206. This ratio multiplied by the billed charge of \$10,000.00 yields a cost of \$2,060.00. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of \$14,492.35 divided by the sum of all APC payments is 61.53%. The sum of all packaged costs is \$927.00. The allocated portion of packaged costs is \$570.41. This amount added to the service cost yields a total cost of \$2,630.41. The cost of this service exceeds the annual fixed-dollar threshold of \$2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is \$0.00. The outlier payment amount is \$0.00. The total APC payment for this service is \$14,492.35. This amount multiplied by 130% yields a MAR of \$18,840.06.
- Procedure code 63650 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0040, which, per OPPS Addendum A, has a payment rate of \$4,553.02. This amount multiplied by 60% yields an unadjusted labor-related amount of \$2,731.81. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of \$2,654.23. The non-labor related portion is 40% of the APC rate or \$1,821.21. The sum of the labor and non-labor related amounts is \$4,475.44. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service, including any applicable outlier payment, is \$4,475.44. This amount multiplied by 130% yields a MAR of \$5,818.07.
- Procedure code 63650 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0040, which, per OPPS Addendum A, has a payment rate of \$4,553.02. This amount multiplied by 60% yields an unadjusted labor-related amount of \$2,731.81. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of \$2,654.23. The non-labor related portion is 40% of the APC rate or \$1,821.21. The sum of the labor and non-labor related amounts is \$4,475.44. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service, including any applicable outlier payment, is \$4,475.44. This amount multiplied by 130% yields a MAR of \$5,818.07.
- Procedure code 95972 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0692, which, per OPPS Addendum A, has a payment rate of \$110.95. This amount multiplied by 60% yields an unadjusted labor-related amount of \$66.57. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of \$64.68. The non-labor related portion is 40% of the APC rate or \$44.38. The sum of the labor and non-labor related amounts is \$109.06. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service, including any applicable outlier payment, is \$109.06. This amount multiplied by 130% yields a MAR of \$141.78.
- Procedure code G0378 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

4. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission." The implantable items were paid separately by the insurance carrier and are not in dispute. Calculation of the reimbursement amount for the implantable items is therefore not addressed in this review. However, review of the submitted information finds that the insurance carrier paid a total amount of \$19,354.50 for reimbursement of the implantable items.
5. The total allowable reimbursement for the services in dispute (not including implantable items) is \$30,617.98. The amount previously paid by the insurance carrier is \$30,637.23, less the amount of \$19,354.50 paid by the insurance carrier for reimbursement of the implantable items, leaves a total payment by the insurance carrier for the disputed services in the amount of \$11,282.73. The requestor is seeking additional reimbursement in the amount of \$19,317.71. This amount is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$19,317.71.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$19,317.71, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Grayson Richardson  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
October 17, 2012  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**